STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115720	A. Building B. Wing	08/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health and Rehabilitation Center	139 Moran Lake Road, NE Rome, GA 30161

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146 Based on staff interviews, record review, and review of the facility's policies titled, Resident Assessment-Coordination with PASARR Program, the facility failed to refer one of 29 residents (R) (R61) for a pre-admission screening and resident review (PASARR) Level II screening. The deficient practice had the potential to place R61 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the policy titled Resident Assessment - Coordination with PASARR Program, dated October 2023, revealed the policy of the facility was to coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Review of the electronic medical record (EMR) revealed R61 was admitted to the facility with diagnoses including, but not limited to, anxiety disorder, major depressive disorder, and schizoaffective disorder. Review of R61's most recent entry tracking Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/10/2024 revealed section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or related condition. Review of the quarterly MDS assessment dated [DATE] revealed Section I (Active Diagnoses) documented no neurological diagnoses and documented schizophrenia, depression, and anxiety. Review of R61's care plan revealed a focus area of mood problems related to diagnoses of depression, schizoaffective disorder, and anxiety. Goals included, but were not limited to, improved mood state. Interventions included, but were not limited to, administering medications as ordered, behavioral health consults as needed, and monitoring/recording/reporting to the medical doctor as needed for mood patterns, signs, and symptoms of depression, anxiety, or sad mood. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/18/2024

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Evergreen Health and Rehabilitation Center	139 Moran Lake Road, NE Rome, GA 30161

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Service Director (SSD) on 8/17/2024 at 10:49 am revealed R61 did not have a PASARR Level II. She revealed that when a new diagnosis or new antipsychotic/antidepressant type medication was added to a resident's medical record, the Director of Nursing (DON) should notify her of the new psychiatric diagnosis or medication ordered, and she would submit for a PASARR Level II. She confirmed R61 had diagnoses of major depressive disorder, anxiety disorder, and schizoaffective disorder and did not have a diagnosis of dementia or Alzheimer's. She stated she was not told about the diagnosis of schizoaffective disorder and that a request for a PASARR Level II should have been submitted. An interview with the DON on 8/17/2024 at 11:04 am revealed the SSD and the MDS Coordinator meet regularly regarding psychiatric medications and diagnoses and that the MDS Coordinator should have notified the SSD of all diagnoses related to R61's mental health. An interview with the MDS/Care Plan Coordinator on 8/17/2024 at 11:06 am revealed that it was the DON's and MDS Coordinator's responsibility to notify the SSD of mental health diagnoses and new mental health medications. She stated she was unable to say why the SSD was not notified of the diagnosis of schizoaffective disorder for R61 but that she should have been notified. She stated this practice could result in R61 not receiving the specialized services he may need. An interview with the DON on 8/17/2024 at 11:50 am revealed the MDS Coordinator should communicate diagnoses to the SSD. She stated the lack of communication could cause the resident to have a mental health issue and cause the resident to be sent to the emergency room and/or hospitalized .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35180 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Comprehensive Care Plans, the facility failed to follow the care plan related to correctly administering the physician ordered rate of oxygen (O2) for two of 15 residents (R) (R41 and R47) receiving O2 therapy. Additionally, the facility failed to follow the care plan related to cleaning the O2 filter on the O2 concentrator (machine that converts room air into oxygen) per physician's orders for two of 15 residents (R32 and R61) receiving O2 therapy. Findings include: A review of the facility policy titled Comprehensive Care Plans, implemented May 2023 revealed under Policy Explanation and Guidelines: . 8. Qualified staff were responsible for carrying out interventions specified in the care plan and will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. 1. A review of the manufacturer's user manual for R32's oxygen concentrator revealed the device should be operated in a clean environment, and excessive dust could affect optimal performance. If environmental conditions were less than optimal, the device would require cleaning more frequently. A review of the electronic medical record (EMR) revealed a physician's (MD) order dated 7/25/2024 revealed R32 was to receive 2 liters per minute (LPM) of oxygen (O2) via nasal cannula (NC) as needed (PRN) and to clean the O2 filter with soap and water (H2O) once a week and as needed. A review of R32's care plan revealed that the staff was to clean the O2 filter on the O2 concentrator per MD order. An observation of R32 on 8/16/2024 at 9:27 am and 8/17/2024 at 8:48 am revealed she was receiving 2 LPM of O2 via NC, per MD orders. An observation of R32's oxygen concentrator on 8/16/2024 at 9:28 am and 8/17/2024 at 9:08 am revealed that the external slats on the O2 concentrator were visibly dirty, with accumulated dust over the entire filter. An observation of the filter inside the concentrator revealed the filter had an accumulation of dust and dirt over the entire internal filter During an interview on 8/17/2024 at 9:44 am with Registered Nurse (RN) CC, he acknowledged the external slats on the O2 concentrator and internal filter on R32's O2 concentrator were dirty and had accumulated dust covering the slats and filter. RN CC confirmed he was responsible for cleaning the filter and concentrator. During an interview on 8/17/2024 at 9:45 am with the Licensed Practical Nurse (LPN DD) revealed that the treatment nurse should clean the O2 concentrators weekly. She stated the O2 tubing and humidifier bottles should be changed weekly and as needed. She revealed this should be documented on the Treatment Administration Record (TAR) for each resident. She verified the O2 concentrator's exterior vent had an accumulation of dust and dirt, and the interior filter was dirty. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Evergreen Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 139 Moran Lake Road, NE Rome, GA 30161	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47146 2. Review of R61's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/15/2024 revealed in Section O (special treatments, procedures, and programs) oxygen therapy was provided to R61 while a resident. Review of R61's care plan indicated a focus of oxygen therapy, diagnosis of asthma, shortness of breath, and altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease and centrilobular emphysema. Goals included but not limited to resident will have no signs or symptoms of poor oxygen absorption, remain free of complications of asthma, and he will maintain a normal breathing pattern. Interventions included but not limited to give medications as ordered by physician (9/13/2023), give oxygen as ordered as needed (9/13/2023), monitor for signs and symptoms of respiratory distress (9/13/2023), monitor for signs / symptoms of asthma attack, and monitor, document, report breathing abnormalities to the physician (9/13/2023), and monitor/document breathing patterns, report abnormalities to the physician (9/13/2023). Review of the EMR revealed physician's orders for R61 included but was not limited to oxygen at two liters per minute via nasal cannula as needed, change oxygen tubing every week and as needed, and clean filter with soap and water every week and as needed. Review of the TAR revealed in August of 2024, change O2 tubing and concentrator cleaned was documented as refused on 8/9/2024 but documented as completed on 8/2/2024 and 8/16/2024. Review of the TAR for July 2024 revealed that the tasks change O2 tubing and concentrator cleaned was documented as completed each week. Observations made on 8/16/2024 at 11:26 am of O2 concentrator at R61's bedside revealed O2 tubing was dated 8/9/2024, the filter vent was covered with a gray substance. Observation made on 8/17/2024 at 7:45 am of the O2 concentrator at R61's bedside revealed a gray substance covered the filter vent. Observed R61 resting in bed receiving O2 at 2 LPM via NC. The NC was dated 8/16/2024. Observation and interview on 8/17/2024 at 9:45 am with LPN DD revealed the O2 concentrators should be cleaned weekly by the treatment nurse. She stated the O2 tubing and humidifier bottles should be changed weekly and as needed. She revealed this was documented on the TAR for each resident who received O2. She confirmed and verified R61's O2 concentrator's filter vent was covered with a fuzzy, gray substance. During an interview on 8/18/2024 at 12:00 pm with the Director of Nursing (DON) revealed R61's care plan included interventions to clean the O2 concentrator and filters. She stated she expected staff to follow the care plan and if a resident refused to allow staff to clean their O2 concentrator/filter they should reapproach the resident at later time. She stated if the resident continued to refuse, then the care plan should reflect this. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/18/2024 at 12:45 pm with the Care Plan Coordinator and the MDS Coordinator revealed that the care plan was developed from the MDS assessment. They stated the care plan interventions should be added reflecting the individual needs of each resident. They stated if a resident was refusing to allow staff to change or clean their equipment, it should be added to the care plan. They stated the care plan for R61 had an intervention added to his care plan which included change tubing, clean and maintain oxygen administration equipment per facility protocol and physician orders (not dated). They stated that they were not aware R61 refused to allow staff to clean the concentrator. 46691 3. A review of R41's quarterly MDS dated [DATE], Section O (Special Treatments, Procedures, and Programs) documented that R41 received oxygen. A review of the active physician's orders revealed an order dated 11/22/2022 for O2 at 2 LPM via NC or mask PRN. A review of R41's care plan revealed a Focus area of the resident uses O2 therapy PRN related to chronic obstructive pulmonary edema (COPD). The Interventions included giving medications as ordered by the physician. A review of the medication administration record (MAR) dated August 2024 documented that O2 was administered at 3 LPM on 8/1/2024, 8/2/2024, 8/3/2024, 8/15/2204 and 8/16/2024. Observations on 8/16/2024 at 11:15 am, 8/16/2024 at 4:00 pm, and 8/17/2024 at 10:00 am revealed R41 receiving O2 via a NC with the flow-meter set at 3.5 LPM. In an interview on 8/17/2024 at 9:10 am, LPN AA confirmed R41's physician's order of O2 at 2 LPM via NC or mask PRN. During observation of R41, LPN AA verified that he was receiving O2 via an NC at 3.5 LPM. LPN AA verified that R41's care plan included a focus area of the resident using O2 therapy PRN related to COPD, and interventions included giving medications as ordered by the physician. She confirmed if the O2 was not administered at the rate ordered by the physician, the care plan was not being followed. She further stated that not following the care plan could cause adverse effects for a resident. In an interview on 8/18/2024 at 1:00 pm, LPN BB confirmed R41's care plan included administering medications as ordered and stated if the O2 was not administered as ordered, the care plan was not being followed. She stated that O2 was considered a medication. In an interview on 8/18/2024 at 1:15 pm, the DON stated she expected licensed nursing staff to follow the interventions on the resident's care plan, and if the intervention stated to administer medications as ordered, the nurse would not be following the care plan if O2 was not being administered as ordered. She stated failing to follow care plan interventions could cause adverse effects for a resident. 44960 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the EMR for R47 revealed she was admitted to the facility with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), encephalopathy, cirrhosis of the liver, diverticulosis and end stage renal disease with dialysis. The resident's most recent Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was coded as 05, which suggests severe cognitive impairment. Review of Physician orders for R47 revealed Oxygen Therapy-Nasal Cannula at rate of two liters PRN, initiated 11/30/2023. Review of the care plan initiated on 12/19/2023 and revised on 3/26/2024 revealed that R47 had diagnosis of sleep apnea, and shortness of breath. Care plan also states order for 02 at 2 LPM via NC PRN. Observation on 8/17/2024 at 8:43 am revealed R47's O2 concentrator set on 3 LPM, being delivered via NC. Observation on 8/18/2024 at 9:20 am and 11:20 am revealed R47's O2 concentrator flow rate set at 3 LPM, being delivered via NC. Observation and interview on 8/18/2024 at 11:35 am with the Assistant Director of Nursing (ADON) confirmed that R34's O2 tank setting was on three LPM. The ADON checked R47's medical orders in the facility's EMR and confirmed that the physician order was for two LPM via NC. The ADON stated R47 had in the past adjusted the flow meter on her 02 concentrator. During an interview on 8/18/2024 at 12:10 pm, R47 stated they never adjusted the knob on the concentrator. R47 further stated only the nurses changed the flow rate on the concentrator. Interview on 8/18/2024 at 2:00 pm with the DON revealed that she expected the care plan to be reconciled with the physician's order and to be followed as written, on the care plan and physician's orders. Cross reference to F-695

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35180 Based on observations, staff interviews, record review, and review of the facility policies titled, Oxygen Administration and Oxygen Concentrator, the facility failed to ensure respiratory equipment was maintained in a sanitary manner for two of 15 residents (R) (R32 and R61) receiving oxygen therapy. In addition, the facility failed to ensure oxygen (O2) was administered according to physician orders for two of 15 residents (R41 and R47) receiving oxygen therapy. The deficient practices could potentially place the resident at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of the facility policy Oxygen Concentrator revised 9/1/ 2022 revealed under Policy: The staff is to follow the manufacturer's recommendations for the frequency of cleaning filters and servicing the device. A review of the facility's undated policy, copyrighted 2024, titled Oxygen Administration revealed under Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The policy further stated under Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of a physician, except in the case of an emergency. 1. A review of the manufacturer's user manual for R32's oxygen concentrator revealed the device should be operated in a clean environment, and excessive dust could affect optimal performance. If environmental conditions were less than optimal, the device would require cleaning more frequently. A review of the electronic medical record (EMR) revealed a physician's (MD) order dated 7/25/2024 revealed R32 was to receive 2 liters per minute (LPM) of oxygen (O2) via nasal cannula (NC) as needed (PRN) and to clean the oxygen (O2) filter with soap and water (H2O) once a week and as needed. An observation of R32 on 8/16/2024 at 9:27 am and 8/17/2024 at 8:48 am revealed she was receiving 2 LPM of O2 via NC, per MD orders. An observation of R32's oxygen concentrator on 8/16/2024 at 9:28 am and 8/17/2024 at 9:08 am revealed that the external slats on the oxygen concentrator were visibly dirty, with accumulated dust over the entire filter. An observation of the filter inside the concentrator revealed the filter had an accumulation of dust and dirt over the entire internal filter. During an interview with Licensed Practical Nurse (LPN DD) on 8/17/2024 at 9:45 am revealed that the treatment nurse should clean theO2 concentrators weekly. She stated the O2 tubing and humidifier bottles should be changed weekly and as needed. She revealed this should be documented on the Treatment Administration Record (TAR) for each resident. She verified the O2 concentrator's exterior vent had an accumulation of dust and dirt, and the interior filter was dirty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/17/2024 at 9:44 am with Registered Nurse (RN) CC, he acknowledged the external slats on the O2 concentrator and internal filter on R32's O2 concentrator were dirty and had accumulated dust covering the slats and filter. RN CC confirmed he was responsible for cleaning the filter and concentrator. During an interview on 8/17/2024 at 9:50 am with the Administrator, she stated the O2 concentrator should have been cleaned weekly, and that acknowledged the exterior slats on the oxygen concentrator and the interior filer were covered with an accumulation of dust and dirt. She stated the treatment nurse cleaned the concentrators and changed the O2 tubing and humidifier bottles every week and recorded this on the TAR. 47146 2. Review of R61's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/15/2024 revealed a Brief Interview for Mental Status (BIMS) of 5, which indicates R61 had severe cognitive impairment. Section O (special treatments, procedures, and programs) indicated oxygen therapy was provided to R61 while a resident. Review of R61's care plan indicated a focus of oxygen therapy, diagnosis of asthma, shortness of breath, and altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease and centrilobular emphysema. Goals included but not limited to resident will have no signs or symptoms of poor oxygen absorption, remain free of complications of asthma, and he will maintain a normal breathing pattern. Interventions included but not limited to give medications as ordered by physician (9/13/2023), give oxygen as ordered as needed (9/13/2023), monitor for signs and symptoms of respiratory distress (9/13/2023), monitor for signs / symptoms of asthma attack, and monitor, document, report breathing abnormalities to the physician (9/13/2023), and monitor/document breathing patterns, report abnormalities to the physician (9/13/2023). Review of the EMR revealed physician's orders for R61 dated 10/4/2023 for O2 @ (at) 2L/M (liters per minute/LPM) VIA NC PRN, change oxygen tubing every week and as needed, and clean filter with soap and water every week and as needed. Review of the TAR for R61 revealed in August of 2024, change oxygen tubing and concentrator cleaned was documented as refused on 8/9/2024 but documented as completed on 8/2/2024 and 8/16/2024. Review of the TAR for July 2024 revealed that the tasks change oxygen tubing and concentrator cleaned was documented as completed each week. Observations made on 8/16/2024 at 11:26 am of the O2 concentrator at R61's bedside revealed O2 tubing was dated 8/9/2024, and the filter vent was covered with a gray substance. Observation made on 8/17/2024 at 7:45 am of the O2 concentrator at R61's bedside revealed a gray substance covered the filter vent. R61was observed resting in bed receiving O2 at two LPM via NC. The NC was dated 8/16/2024. Observation and interview on 8/17/2024 at 9:45 am, she confirmed and verified R61's O2 concentrator's filter vent was covered with a fuzzy, gray substance. (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 8/18/2024 at 1:33 pm with RN CC revealed he did not remember R61 refusing to allow him to change oxygen tubing or clean his O2 concentrator. He stated when R61 refused, he typically reapproached at a later time to attempt to complete the task. He stated he also would complete this task when R61went out to smoke. He stated that if he was able to complete the task after the resident previously refused, he would/should document the task was completed but also revealed that the EMR was sometimes frustrating because it didn't load in a timely manner and he may have forgotten to complete the task.

46691

3. A review of R41's quarterly MDS, dated [DATE], revealed section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) of 5 (indicating severe cognitive impairment) and section O (Special Treatments, Procedures, and Programs) documented that R41 received oxygen.

A review of the active physician's orders revealed an order dated 11/22/2022 for O2 at 2 LPM via NC or mask PRN.

A review of R41's diagnoses list revealed diagnoses included chronic obstructive pulmonary edema (COPD) and respiratory failure.

A review of the MARs dated 8/2024 documented that O2 was administered at 3 LPM on 8/1/2024, 8/2/2024, 8/3/2024, 8/15/2204 and 8/16/2024.

A review of the Progress Notes revealed no documentation of respiratory distress.

Observations on 8/16/2024 at 11:15 am, 8/16/2024 at 4:00 pm, and 8/17/2024 at 10:00 am revealed R41 receiving O2 via a NC with the flow-meter set at 3.5 LPM.

In an interview on 8/16/2024 at 4:00 pm, R41 stated he used the O2 as he felt he needed it, and the staff set the flow rate for him. He stated he did not adjust the settings.

In an interview on 8/17/2024 at 9:10 am, LPN AA stated the nurses were responsible for ensuring residents received medications, including O2, as ordered by the physician. She stated nurses should check the physician's order each shift to ensure the O2 was being administered according to the physician's order. LPN AA confirmed R41's physician's order for O2 at 2 LPM via NC or mask PRN. During observation of R41, LPN AA verified that he was receiving O2 via an NC at 3.5 LPM. She stated she was unsure why R41's O2 was set to deliver 3.5 LPM and further stated since R41 had COPD, he could have adverse effects from receiving too much O2, and the flow meter should be monitored at least every shift to ensure O2 was administered as ordered.

In an interview on 8/18/2024 at 1:15 pm, the DON stated she expected licensed nursing staff to administer O2 as ordered by the physician. She further stated the nurse should notify the physician if a resident experienced respiratory distress and should not adjust the O2 flow rate without a physician's order. She stated administering O2 at a rate higher than the ordered rate could cause adverse health effects for the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the EMR for R47 revealed she was admitted to the facility with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), encephalopathy, cirrhosis of the liver, diverticulosis and end stage renal disease with dialysis. The resident's most recent MDS dated [DATE] revealed a BIMS score was coded as 05, which suggests severe cognitive impairment. Review of Physician orders for R47 revealed an order for O2 @ 2L/M (LPM) VIA NC PRN, initiated 11/30/2023. Review of the care plan initiated on 12/19/2023 and revised on 3/26/2024 revealed that R47 has diagnosis of sleep apnea, and shortness of breath. Observation on 8/17/2024 at 8:43 am revealed R47's O2 concentrator set on 3 LPM being delivered via NC. Observation on 8/18/2024 at 9:20 am and 11:20 am revealed R47's O2 concentrator flow rate set at 3 LPM, being delivered via NC. Observation and interview on 8/18/2024 at 11:35 with the Assistant Director of Nursing (ADON) confirmed that R47's O2 tank setting was set on 3 LPM. ADON checked R47's medical orders in the facility's EMR and confirmed that the physician order was for two LPM via NC. During an interview on 8/18/2024 at 12:10 pm, R47 stated she never adjusts the knob on the concentrator. R47 further stated only the nurses change the flow rate on the concentrator, and that she only adjusts her tubing.